STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

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1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ____ No limitations X With limitations*

2. a. Outpatient hospital services.

   Provided: ____ No limitations X With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise included in the State plan).

   X Provided: X No limitations ____ With limitations*
   __ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: X No limitations ____ With limitations*

3. Other laboratory and x-ray services.

   Provided: X No limitations ____ With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

   Provided: _____ No limitations X With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

   c. Family planning services and supplies for individuals of child-bearing age.

   Provided: _____ No limitations X With limitations*

5. a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

   Provided: _____ No limitations X With limitations*

   b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

   Provided: _____ No limitations X With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

   a. Podiatrists' services.

   Provided: _____ No limitations X With limitations*

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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6. b. Optometrists' services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

c. Chiropractors' services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

d. Other practitioners' services.

X Provided: Identified on attached sheet with description of limitations, if any.
____ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: __ No limitations X With limitations*

b. Home health aide services provided by a home health agency.

Provided: ____ No limitations X With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: ____ No limitations X With limitations*

*Description provided on attachment.

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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7. d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

X Provided: __ No limitations X With limitations*
__ Not provided.

8. Private duty nursing services.

X Provided: __ No limitations X With limitations*
_____ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

9. Clinic services.

X Provided: ____ No limitations X With limitations*
__ Not provided.

10. Dental services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

X Provided: __ No limitations X With limitations*
____ Not provided.

b. Occupational therapy.

X Provided: __ No limitations X With limitations*
____ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

X Provided: __ No limitations X With limitations*
____ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

    a. Prescribed drugs.

    X Provided: __ No limitations X With limitations*
    _____ Not provided.

    b. Dentures.

    X Provided: __ No limitations X With limitations*
    _____ Not provided.

    c. Prosthetic devices.

    X Provided: __ No limitations X With limitations*
    _____ Not provided.

    d. Eyeglasses.

    X Provided: __ No limitations X With limitations*
    _____ Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

    a. Diagnostic services.

    X Provided: _____ No limitations X With limitations*
    __ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

13. b. Screening services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

c. Preventive services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

d. Rehabilitative services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

b. Skilled nursing facility services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

c. Intermediate care facility services.

X Provided: ____ No limitations X With limitations*
____ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

---

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

    X Provided: ____ No limitations X With limitations*
    __ Not provided.

    b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

    X Provided: ____ No limitations X With limitations*
    __ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

    X Provided: ____ No limitations X With limitations*
    ____ Not provided.

17. Nurse-midwife services.

    X Provided: ____ No limitations X With limitations*
    __ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

    X Provided: ____X No limitations __ With limitations*
    __ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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19. Case management services and Tuberculosis related services

    a. Case management services as defined in, and to the group specified in, Supplement 1 to ATTACHMENT 3.1-A (in accordance with section 1905(a)(19) or section 1915(g) of the Act).

    X Provided: __ No limitations __ With limitations
    _____ Not provided.

    b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

    X Provided: __ No limitations X With limitations
    __ Not provided.

20. Extended services for pregnant women

    a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

    _____ Additional coverage **

    b. Services for any other medical conditions that may complicate pregnancy.

    X Additional coverage **

*Description provided on attachment.

**Attached is a description of increases in covered services beyond limitations for all groups described in this attachment and/or any additional services provided to pregnant women only.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

---

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by an eligible provider (in accordance with section 1920 of the Act).

X Provided: X No limitations __ With limitations*
_____ Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act.

_____ Provided: __ No limitations __ With limitations*
X Not provided.

23. Certified pediatric or family nurse practitioners' services.

X Provided: _____ No limitations X With limitations*

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

---

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

    a. Transportation.

    X Provided: _____ No limitations X With limitations*
    __ Not provided.

    b. Services provided in Religious Non-medical Health Care Institutions.

    __ Provided: _____ No limitations __ With limitations*
    X Not provided.

    c. Reserved.

    d. Nursing facility services for patients under 21 years of age.

    X Provided: _____ No limitations X With limitations*
    __ Not provided.

    e. Emergency hospital services.

    X Provided: ____X No limitations __ With limitations*
    __ Not provided.

    f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

    X Provided: _____ No limitations X With limitations*
    __ Not provided.

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY (Continued)

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25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

__ Provided
X Not provided

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Case management services are provided to a woman with a medically verifiable pregnancy who is a Medicaid client or who meets the financial requirement for presumptive eligibility to receive ambulatory prenatal care services provided by a provider that is eligible for payment under the State Plan.

The Case Manager for this program will be known as the Perinatal Care Coordinator.

B. Areas of State in Which Services Will Be Provided:

X Entire State

__ Only in the following geographic areas. Authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of Services

Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services:

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psycho social, nutritional, educational and other services for the pregnant woman.

This coordination process requires the skill and expertise of professionals who have broad knowledge of perinatal care, interviewing and assessment techniques, alternative community resources, and referral systems required to develop an individual service plan.

The Perinatal Care Coordinator serves as a liaison between clients and individuals or agencies involved in providing care, as a contact person for the client and family, as a resource to prepare and counsel the client regarding essential services that are determined necessary and scheduled for the client.

Needs of pregnant women are individual and influenced by varying medical, personal, socioeconomic and psycho social factors. A plan of care with intervention to meet identified needs or resolve problems may be indicated on a limited, intermediate, or comprehensive basis. The initial assessment made by the Perinatal Care Coordinator will be the basis for determining the level of care and the extent of coordination and monitoring necessary for each individual.

Monitoring of the individual plan of services by the Perinatal Care Coordinator is essential to minimize fragmentation of care, reduce barriers, link clients with appropriate service, and assure that services are provided consistent with optimal perinatal care standards.

Monitoring involves direct contact with the client through clinic, home visits, or telephone contact. Monitoring includes a contact resulting in assessment, planning of care and services, and reevaluation of the plan of care. Monitoring may also include consultation with care providers to assess the need for further follow-up or coordination and arrangement of necessary services.

The number, duration, scope and interval between contacts will vary among clients and even across one client's pregnancy. At a minimum, contacts, including telephone contacts with the client, must include: assessment and documentation of current physical, psycho social, socioeconomic, and nutritional status. Follow-up on the outcome of previous referrals must be included along with documentation of any referrals arranged for additional services. Anticipatory guidance regarding pregnancy and parenting must also be documented.

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State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

A record of contacts made with the client or with providers on behalf of the client, and services arranged or provided by the Perinatal Care Coordinator must be documented and maintained in the medical record, and must include:

Name of recipient,
Date of service,
Name of provider agency and person providing the service,
Place of service,
Nature and extent of the service, including outcome of the contact,
Intake assessment,
Individualized care plan (including risk factors and proposed referrals to deal with those risk factors), and
Changes to care plans as indicated by contact with client or providers.

Providers of perinatal care coordination services are expected to meet the following qualifications:

Registered Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Certified Registered Nurse Midwife -- Licensed in accordance with the Certified Nurse Midwifery Practice Act of the State of Utah.

Certified Family Nurse Practitioner -- Licensed in accordance with the Nurse Practice Act of the State of Utah.

Social Service Worker (SSW) -- With a minimum of a bachelor's degree in social work, and licensed in accordance to the Social Work Licensing Act of the State of Utah.

Licensed Certified Social Worker (LCSW) -- With a minimum of a master's degree in social work, and licensed in accordance to the Social Work Licensing Act of the State of Utah.

Health Educator -- Bachelor's degree in health education with a minimum of three years experience, at least one of which must be in a medical setting.

Health Educator -- Master's degree with a minimum of one year of experience working in a medical setting or with pregnant women.

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CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

Certified Health Education Specialist -- With a minimum of a bachelor's degree and a certificate showing completion of a certification examination in health education.

Licensed practical Nurse -- Licensed in accordance with the Nurse Practice Act of the State of Utah. Must have additional training and experience to meet the expectations of the Perinatal Care Coordinator and must work under the supervision of a registered nurse.

Provided by: Perinatal Care Coordinator who is an enrolled Medicaid provider
Billed by: Perinatal Care Coordinator using a HCFA 1500 Claim Form
Billing Code: Y7000 Perinatal Care Coordinator

E. Qualification of Providers:

Recipients will have the free choice of any enrolled qualified Case Manager (Perinatal Care Coordinator). Qualified Case Managers are registered nurses, certified nurse midwives, certified family nurse practitioners, licensed social service workers, certified social workers, health educators or licensed practical nurses licensed under the authority of Title 58 (Occupational and Professional Licensing) of the Utah Code Annotated, 1953 as amended, practicing within the scope of their licensure, and recognized by the Utah Department of Health, Division of Health Care Financing and the Division of Family Health Services prenatal program.

The Case Manager (Perinatal Care Coordinator) can be employed by a physician who is a Medicaid provider, or employed by a Qualified Provider of Presumptive Eligibility services.

F. The State assures that the provision of Case Management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.
1. Eligible recipients will have free choice of the providers of Case Management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for Case Management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are provided to chronically mentally ill Medicaid eligibles who are not otherwise eligible for targeted case management service as part of another approved target group. The need for case management service will be identified by a physician or other mental health professional in the recipient's treatment plan for mental health clinic, outpatient hospital, or physician

B. Areas of State in Which Services Will Be Provided:

X Entire State

__ Only in the following geographic areas. Authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide.

C. Comparability of Services

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services

Targeted case management services are a set of planning, coordinating, and monitoring activities that assist individuals in the target group to access needed medical, social, educational, and other services and thereby promote the individual's ability to function independently and successfully in the community.

1. Covered case management activities include:

   a. Assessment of the recipient's potential strengths, resources, and needs and the development of a comprehensive service plan in conjunction with the recipient, family, and other significant individuals;

   b. Advocating for, and linking the recipient with, services identified in the service plan such as mental health, housing, medical, social, or nutritional services;

   c. Assisting the recipient to acquire necessary independent living skills such as compliance with the prescribed medication regimen, preparing for job interviews, managing money; and assisting the recipient during acute crisis episodes to ensure the provision of the most appropriate cost-effective service;

   d. Coordinating the delivery of needed service and monitoring to assure the appropriateness and quality of services delivered including coordinating with the hospital and nursing facility discharge planner in the 30-day period prior to the patient's discharge into the community. (This is the only case management service provided to hospital or nursing facility inpatients and is limited to a maximum of five hours per patient per inpatient hospitalization.) In addition, case management services will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease;

   e. Monitoring to assess the recipient's progress and continued need for service.

2. Non-covered services include:

   a. Medical or other treatment services;

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State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

b. Outreach to individuals who may or may not be eligible for case management services;

c. Consultation with other mental health staff in the same agency.

E. Qualifications of Providers:

Qualified case managers include:

1. Licensed mental health professionals (psychologist, certified or clinical social workers, social service workers, registered nurse with training or experience in psychiatric nursing, marriage and family therapist) employed by comprehensive community mental health clinics; or

2. Non-licensed individuals who have met the State Division of Mental Health's training standards for case managers and who are supervised by a licensed mental health professional listed in section E-1 above.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group

Targeted case management services are provided to Medicaid eligibles who:

1. Reside in a Salt Lake, Summit, Wasatch, Weber, or Utah County emergency homeless shelter capable of providing temporary shelter for at least 30 days in order to assure that sufficient case management services are provided to successfully reintegrate the homeless into the community; and

   a. Do not otherwise have a permanent address or residence in which they could reside; and

   b. Do not live in a boarding home, residential treatment facility which houses only victims of domestic abuse; and

   c. Are not receiving targeted case management services as part of another approved target group; or

2. Have left the homeless shelter; and

   a. Require continued targeted case management services to prevent a recurrence of homelessness; and

   b. Are not receiving targeted case management services as part of another approved target group.

The need for case management services will be identified by the qualified provider in the recipient's needs assessment.

B. Areas of State in Which Services Will Be Provided

__ Entire State

X Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide: Salt Lake, Summit, Wasatch, Weber and Utah counties).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

C. Comparability of Services

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Targeted case management services are a set of planning, coordinating, and monitoring activities that assist recipients in the target group to access needed housing, employment, medical, nutritional, social, education and other services to promote independent living and functioning in the community.

1. Covered case management activities include:

   a. Assisting the recipient to determine need for services and developing a service plan to assure adequate access to necessary services and community resources;

   b. Advocating for, and linking the recipient with, required services and community resources identified in the service plan;

   c. Assisting the recipient to acquire necessary independent living skills;

   d. Coordinating the delivery of services including coordinating with the hospital and nursing facility discharge planner in the thirty-day period prior to the recipient's discharge to the homeless shelter. (This is the only case management service provided to hospital or nursing facility inpatients and is limited to a maximum of three hours per patient per year. Case management services will not be provided to individuals between the ages of 22 and 64 who are inpatients in institutions for mental disease);

   e. Monitoring to assure the appropriateness and quality of services delivered and to assess the recipient's progress and continued need for service.

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State: UTAH

CASE MANAGEMENT SERVICES (Continued)

E. Qualifications of Providers:

Qualified case managers include:

1. Licensed physician, licensed psychologist, certified or clinical social worker, registered nurse, licensed marriage and family therapist, or licensed social service worker who is available to provide comprehensive case management services on a 24-hour a day basis to ensure the homeless individual's successful reintegration into the community; or

2. Non-licensed individuals who are supervised by one of the licensed qualified providers listed in section E-1 above.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group

Target case management services are provided to Medicaid eligibles who have a diagnosis of HIV/AIDS. The need for case management services will be identified by the qualified provider in the recipient's needs assessment.

B. Areas of State in Which Services Will Be Provided

X Entire State

__ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide: Salt Lake, Weber and Utah counties).

C. Comparability of Services

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Targeted case management services are a set of planning, coordinating, and monitoring activities that assist recipients in the target group to access needed housing, employment, medical, nutritional, social, education and other services

1. Covered case management activities include:

   a. Assisting the recipient to determine need for services and developing a service plan to assure adequate access to necessary services and community resources;

   b. Advocating for, and linking the recipient with, required services and community resources identified in the service plan;

   c. Assisting the recipient to acquire necessary independent living skills;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

d. Coordinating the delivery of services including coordinating with the primary care provider/attending physician;

e. Monitoring to assure the appropriateness and quality of services delivered and to assess the recipient's progress and continued need for service.

E. Qualifications of Providers:

The recipients will have the free choice of any enrolled and qualified case managers. Qualified case managers must have experience in accessing services such as housing, medical, nutritional, etc. Qualified case managers include:

1. Licensed social service workers employed by an agency or organization designed to meet the specialized needs of the target group; or

2. Licensed psychologists, certified or clinical social workers, or registered nurses who have experience in working with and assisting HIV/AIDS clients.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

H. Qualifications of Providers

Qualified case managers include:

1. Licensed physician, licensed psychologist, certified or clinical social worker, registered nurse, licensed marriage and family therapist or licensed social service worker who is available to provide comprehensive case management services on a 24-hour a day basis to ensure the homeless individual's successful reintegration into the community; or

2. Non-licensed individuals who are supervised by one of the licensed qualified providers listed in section E-1 above.

I. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

J. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group

1. Targeted case management services are provided to Medicaid eligibles who are assessed as having a primary diagnosis of a chemical dependency or substance abuse; and

2. In addition, recipients of targeted case management services must demonstrate lack of adequate or available support networks and one or more of the following:

   a. Failure or inability to comply with treatment regimen or to access needed services independently;

   b. Experience frequent crisis episodes; or

   c. Require multiple services and their coordination.

3. The need for targeted case management services will be documented.

B. Areas of State in Which Services Will Be Provided

X Entire State

__ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

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State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services

1. Targeted case management services are defined as those services that promote the effective and efficient utilization of resources, assure access to necessary comprehensive services, and prevent duplication of services.

2. Covered case management activities include:
   a. Assessing the recipient's potential risk factors, determining the need for services, and developing a service plan to assure adequate access to necessary services and community resources;
   b. Advocating for and building linkages for the recipient with basic community resources;
   c. Assisting in the access of needed services and monitoring to assure the appropriateness and quality of services delivered;
   d. Monitoring to assess the recipient's progress, and maintenance of treatment goals and participation in transition and aftercare activities.

E. Qualifications of Providers:

The recipients will have the free choice of any enrolled and qualified case manager. Qualified case managers are:

1. Licensed substance abuse professionals (psychologist, certified or clinical social worker, social service worker, registered nurse, professional counselor, and marriage and family therapist) employed by an agency that is under contract with or directly operated by a Local County Comprehensive Substance Abuse Plan; or
2. Non-licensed individuals who are supervised by a licensed professional listed in Section E-1 above.

F. The State assures that the provision of optional targeted case management services to eligible individuals will not restrict the right of those individuals to the free choice of service providers (Section 1902(a)(23) of the Act).

1. Eligible recipients will have free choice of the provider of their case management services.
2. Eligible recipients will have free choice of (other) medical care providers under the plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

G. Payment for targeted case management services will not duplicate payments made to public agencies, or private entities under other program authority, for the same purpose of targeted case management. Payment under this provision will not be made for case management services that are an integral part of another provider service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Tuberculosis services are provided to recipients exposed to tuberculosis eligible under any group under the State Plan.

B. Areas of State in Which Services Will Be Provided

X Entire State

__ Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services

__ Services are provided in accordance with section 1902(a)(10)(B) of the Act.

X Services are not comparable in amount, duration, and scope. Authority of section 1915(a) of the Act, is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services

Targeted case management services are a set of planning, coordinating and monitoring activities that assist recipients in the target group to access needed housing, medical, nutritional, social, education and other services.

Covered case management activities include:

a. Assisting the recipient to determine need for services and developing a service plan to assure adequate access to necessary services and community resources;

b. Advocating for and linking the recipient with required services and community resources identified in the service plan;

c. Assisting the recipient to access necessary independent living skills;

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES (Continued)

D. Definition of Services (Continued)

d. Coordinating the delivery of services including coordinating with the primary care provider/attending physician;

e. Monitoring to assure the appropriateness and quality of services delivered and to assess the recipient's progress and continued need for services.

E. Qualifications of Providers:

Recipients will have the free choice of any enrolled qualified case managers. Qualified case managers must have experience in accessing services such as housing, medical, nutritional, etc. Qualified case managers include:

1. Registered nurses, certified or clinical social workers who have experience in working with and assisting TB clients.

F. The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are available to Medicaid eligible HMO ("Plan") enrollees and potential enrollees who a qualified case manager has determined:

1. Require assistance to identify, obtain access to, and coordinate medical and other services consistent with their identified needs; and for whom

2. There is a reasonable indication that the enrollee or potential enrollee will obtain the required assistance only through a qualified targeted case manager.

B. Areas of the State in Which Services Will Be Provided:

Services will be limited to the following geographic areas of the state: the urban counties of Davis, Salt Lake, Utah, and Weber.

C. Comparability:

Services are not comparable in amount, duration, and scope. Authority of Sec. 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Sec. 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. This service is designed to assist eligible individuals in the target group ("clients") to identify and appropriately utilize the scope of medical and other services available to them.

2. Federal Financial Participation will be available at the FMAP percentage for costs incurred to perform the following activities/services with, and on behalf of, clients in the target group.

   a. assessing the eligible client's need for medical and other services including high risk assessments with all aged and disabled recipients;
   b. linking the client through direct or indirect referral with medical services and community resources in accordance with their identified needs;
   c. coordinating the availability of and the access to necessary services, acting as the liaison between the client, Plan, providers, and applicable public and private agencies;
   d. periodic follow-up and assistance as the recipient's service needs change; and
   e. instructing the client or the client's legal representative when applicable, in independently identifying, obtaining, and coordinating needed services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: UTAH

CASE MANAGEMENT SERVICES

E. Qualified Providers:

Health Program Representatives (HPRs) employed by the State of Utah, Division of Health Care Financing, Bureau of Managed Health Care.

F. Freedom of Choice:

___The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Sec. 1902(a)(23) of the Act, except as authorized under the State's approved 1915(b) freedom of choice waiver.

1. Eligible recipients will have free choice of qualified providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payment:

___

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose. Case management services provided by HRPs is solely for the purpose of augmenting, not supplanting or duplicating, service coordination activities that may be available to recipients through their Plan or other community providers. Services will be available only to Medicaid eligibles. Direct and indirect administrative activities related to the determination of Medicaid eligibility are outside the scope of services offered under this plan.

INPATIENT HOSPITAL SERVICES

DEFINITION

Inpatient Hospital Service means service provided in a hospital licensed by the Utah Department of Health as a hospital -- general as defined by the Utah Code Annotated, Section 26-21-2(8), 1990, as amended; and by Utah Administrative Code, R432-100-1 and R432-100-2.101, 1992, as amended.

LIMITATIONS

1. The lower of the Western Region Professional Activities Study at the 50th percentile or the State of Utah's 50th percentile will be established as the upper limit of length of stay as a utilization control for the most frequent single cause of admission. These criteria will be used to evaluate the length of stay in hospitals that are not under the DRG payment system.

2. Need for an extension of length of stay must be justified by a physician, and reauthorization must be obtained from the Medicaid Agency for hospitals that are not under the DRG payment system.

3. Inpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not provided in all hospitals in the state, and therefore, are non-covered services.

4. Inpatient hospital care for treatment of alcoholism and/or drug dependency is not a service provided in all hospitals in the state, and therefore, the service is limited to acute care for detoxification only.

5. Procedures determined to be cosmetic, experimental, or of unproven medical value, are non-covered services.

6. Organ transplant services are limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

7. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

8. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval. A list will be maintained in the Medicaid Inpatient Hospital Provider Manual.

9. Except for item 7 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. that the proposed services are medically appropriate; and
   b. that the proposed services are more cost effective than alternative services.

OUTPATIENT HOSPITAL SERVICES

DEFINITION

Outpatient Hospital means a facility that is in, or physically connected to, a hospital licensed by the Utah Department of Health as a hospital - general, as defined by Utah Code Annotated, Section 26-21-2(8), 1990, as amended; and by Utah Administrative Code, R432-100-1 and 432-100.101, 1992, as amended.

LIMITATIONS

1. Procedures determined to be cosmetic, experimental, or of unproven medical value, are not a benefit of the program.

2. Outpatient hospital psychiatric counseling services provided under personal supervision, rather than directly by the physician, are not generally furnished by most hospitals in the state, and therefore, are non-covered services.

3. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

4. Selected medical and surgical procedures are limited by federal regulation and require review, special consent, and approval. A list will be maintained in the Medicaid Outpatient Hospital Provider Manual.

5. Except for item 3 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
   a. that the proposed services are medically appropriate; and
   b. that the proposed services are more cost effective than alternative services.

6. The Division shall impose a co-payment for each outpatient hospital visit, maximum of one per date of service, when a non-exempt Medicaid client, as designated on his Medicaid card, receives the outpatient hospital service. The Division shall limit the out-of-pocket annual expense to $100 per client. These amounts as designated in R414-3A-8.
   a. The Division shall deduct the co-pay amount from the reimbursement paid to the physician provider, up to the annual maximum.
   b. The provider should collect the co-payment amount from the Medicaid client for each visit requiring a co-payment.
   c. There are categories of Medicaid clients who are exempt from the co-payment requirement, as designated in R414-10-8.
   d. Services rendered for family planning purposes are exempt from the co-payment requirement.

SKILLED NURSING FACILITY SERVICES

DEFINITION

Skilled nursing facility services (other than services in an institution for mental disease) for individuals 21 years of age or older determined, in accordance with section 1902(a)(28) of the Act, to be in need of such care.

In accordance with section 1919(f)(7) of the Act, personal hygiene items and services may be charged to the patient's personal needs fund. The following limitations apply.

LIMITATIONS

1. The following personal hygiene items and services may, at the request of the patient or the patient's advocate, be charged to the patient's personal needs fund:

    a. Personal grooming services such as cosmetic hair and nail care;

    b. Personal laundry services;

    c. Specific brands of shampoo, deodorant, soap, etc. requested by the patient or patient's advocate and not ordinarily supplied by the nursing home as required in 2(a) and (b) below.

2. In accordance with State Plan amendment 4.19-D, Nursing Home Reimbursement, the following personal hygiene items and services may not be charged to the individual's personal needs fund:

    a. Items specific to a patient's medical needs, such as protective absorbent pads (such as Chux), prescription shampoo, soap, lotion, etc.

    b. General supplies needed for personal hygiene such as toothpaste, shampoo, facial tissue, disposable briefs (diapers), etc.

3 The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. that the proposed services are medically appropriate; and

    b. that the proposed services are more cost effective than alternative services.

MEDICALLY NECESSARY SERVICES

DEFINITION

Medically necessary services not otherwise provided under the state plan but available to EPSDT (CHEC) eligibles.

LIMITATIONS

Other necessary health care, diagnostic services, treatment, and other measures described in Section 1905(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by EPSDT (CHEC) screening services will be provided when medically necessary to EPSDT eligibles. Services not provided under the plan but now available to EPSDT eligibles if medically necessary are:

1. Occupational therapy
2. Orthodontia
3. Medical or other remedial care provided by licensed practitioners:
    a. Chiropractic services

MEDICALLY NECESSARY SERVICES (Continued)

Medically necessary services not otherwise provided under the state plan but available to EPSDT (CHEC) eligibles (Continued)

Diagnostic, Preventive, Rehabilitative Services

A. Early intervention services are diagnostic and treatment services to prevent further disability and improve the functioning of infants and toddlers up to age four with disabilities.

    1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, or communication deficits; and
    2. Information and skills training to the family to enable them to enhance the health and development of the child.

B. Skills development services are medically necessary diagnostic and treatment services provided to children between the ages of 2 and 22 to improve and enhance their health and functional abilities and prevent further deterioration. Services include:

    1. Individual or group therapeutic interventions to ameliorate motor impairment, sensory loss, communication deficits, or psycho social impairments; and
    2. Information and skills training to the family to enable them to enhance the health and development of the child.

Services may be provided at the early intervention site, day care site, in the child's home, at the child's school as needed in accordance with the Individualized Family Service Plan (IFSP) or the Individualized Educational Plan (IEP). Children between the ages of 2 and 4 will be served in the setting that best meets their needs in accordance with the IFSP or IEP. All services are prescribed in accordance with state law.

Early intervention and skills development services are provided by or under the supervision of:

A. A licensed physician, registered nurse, dietician, clinical social worker, psychologist, audiologist, speech and language pathologist, occupational therapist, physical therapist, practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953); or
B. An early childhood special educator certified under Section 53A-1-402 of the Utah Code Annotated, as amended in 1953); or
C. Qualified mental retardation professional (QMRP) as defined in 42 CFR 483.430.

Qualified providers include entities operated by or under contract with the state Maternal and Child Health Title V Grantee agency responsible for Part H of the Individual with Disabilities Education Act (PL 102-119) to provide early intervention services; or school districts that provide special education and related services under Part B of the Individuals with Disabilities Education Act.

MEDICALLY NECESSARY SERVICES (Continued)

Medically necessary services not otherwise provided under the state plan but available to EPSDT (CHEC) eligibles (Continued)

Other Diagnostic, Preventive, Rehabilitative Services

LIMITATIONS

Diagnostic, Preventive, and Rehabilitative Services for EPSDT Participants [42 CFR 440.130(a)(c) and (d)].

Diagnostic, preventive, and rehabilitative health services for EPSDT participants provided by or through a Maternal and Child Health (Title V grantee) Clinic are covered benefits. Such services may be provided in other settings as appropriate.

Services are recommended by a physician and delivered according to a plan of care that is reviewed periodically by the physician. Services, including early intervention services, are provided by a licensed practitioner, including a licensed physician, registered nurse, dietician, clinical social worker, psychologist, audiologist, speech and language pathologist, occupational therapist, or physical therapist practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing, of the Utah Code Annotated 1953, as amended.

MEDICALLY NECESSARY SERVICES (Continued)

Early Childhood services not otherwise provided under the State Plan but available to EPSDT (CHEC) eligibles (Continued)

A. Target Group

Targeted case management for Medicaid eligible children ages birth to four, for whom the service is determined to be medically necessary. Targeted case management services will be considered medically necessary when a needs assessment completed by a qualified targeted case manager documents that:

1. The individual requires treatment and/or services from a variety of agencies and providers to meet his or her documented medical, social, education, and other needs; and

2. There is a reasonable indication that the individual will access needed services only if assisted by a qualified targeted case manager who (in accordance with an individualized case management service plan) locates, coordinates, and regularly monitors the services.

B. Areas of the State in Which Services Will Be Provided:

Services will be available statewide.

C. Comparability:

Services are not comparable in amount, duration and scope. Authority of Section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of Section 1902(a)(10)(B) of the Act.

D. Definition of Services:

1. Targeted case management is a service that assists the eligible clients in the target group to gain access to needed medical, social, educational, and other services. The overall goal of the service is not only to help Medicaid recipients to access needed services, but to ensure that services are coordinated between all agencies and providers involved.
2. The following activities/services are covered by Medicaid under targeted case management:
   a. assessing and documenting the client's need for community resources and services;
   b. developing a written, individualized, and coordinated case management service plan to assure the child's adequate access to needed medical, social, educational, and other related services with input, as appropriate, from the child, family, and other agencies knowledgeable about the child's needs;
   c. linking the child with community resources and needed services, including assisting the child to establish and maintain eligibility for entitlements other than Medicaid;
   d. coordination of the delivery of services to the child, including coordination with the child's MCO medical case manager (where assigned), CHEC screenings and follow-up;
   e. monitoring the quality and appropriateness of the child's services;
   f. instructing the child's caretaker, as appropriate, in independently obtaining access to needed services for the child;
   g. accessing, periodically, the child's status and modifying the targeted case management service plan as needed; and
   h. monitoring the child's progress and continued need for targeted case management and other services.

MEDICALLY NECESSARY SERVICES (Continued)

D. Definition of Services (Continued)

3. Targeted case management services provided to a Medicaid eligible child in a hospital, nursing facility, or other institution may be covered only in the 30-day period prior to the child's discharge into the community.

E. Qualified Providers

1. Medicaid providers of Early Childhood targeted case management services for eligible children may include:
   a. An individual who is licensed as a Registered Nurse in the State of Utah, and is employed by a local, state or district health department; or
   b. An agency that specializes in providing case management services to children and meets the following four criteria:
      i. Is authorized and responsible as outlined in Utah Code Annotated, Section 17-5-243, to provide directly or indirectly, basic public health services as outlined in Utah Code, Section 26A-1-106(3);
      ii. Employees or contracts with Registered Nurses who perform targeted case management assessments and follow-up services. The agency may use non-licensed individuals to provide follow-up targeted case management services under the supervision of qualified Registered Nurse, if the individual has education and experience related to high risk children and has completed training using a targeted case management curriculum approved by the DHCF. The DHCF will approve training curriculums that include:
         - detailed instruction in the Medicaid targeted case management provider manual requirements, and methods for delivering and documenting covered case management services;
         - detailed instruction in the Utah Medicaid CHEC/EPSDT provider manual;
         - up-to-date information on community resources, and how to access those resources; and
         - techniques and skills in communicating successfully with clients and other agency/provider personnel.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of Section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of providers of case management services.
2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Non-Duplication of Payment:

Payment for case management services under the plan shall not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

MEDICALLY NECESSARY SERVICES (Continued)

Diagnostic, Screening, Preventive, and Rehabilitative Services (Continued)

LIMITATIONS

Diagnostic and Rehabilitative Mental Health Services

Diagnostic and rehabilitative mental health services for EPSDT eligibles are limited to medically necessary services designed to promote the client's mental health, reduce the client's mental disability, and restore the client to the highest possible level of functioning.

1. Diagnostic services include mental health evaluation, psychiatric evaluation and psychological testing. Rehabilitative services include individual and group therapy, individual and group behavior management, medication management, skills development services, and skills development programs.

   Skills development services means rehabilitative services provided to an individual or group of individuals that are designed to (1) assist individuals to develop competence in basic living skills in areas including, but not limited to, food planning, shopping, food preparation, money management, mobility, grooming, personal hygiene and maintenance of the living environment, and ensure appropriate compliance with the medication regimen; (2) assist individuals to develop community awareness, and (3) assist individuals to develop appropriate social and interpersonal skills and behaviors. Skills development services may also include supportive counseling directed toward eliminating psycho-social barriers that impede the individual's ability to function successfully in the community.

   Skills development program means a licensed 24-hour comprehensive residential program, group home, or family-based foster care program that is operated by or under contract with the Department of Human Services (DHS) to provide an array of diagnostic and rehabilitative services as specified in the contract between DHS and the program, and up to 24-hour supervision in a structured setting for children who are experiencing social, emotional, or behavioral problems.

MEDICALLY NECESSARY SERVICES (Continued)

Diagnostic, Screening, Preventive, and Rehabilitative Services (Continued)

LIMITATIONS

Diagnostic and Rehabilitative Mental Health Services (Continued)

2. Diagnostic and rehabilitative mental services are covered benefits when provided: (1) by or under the supervision of a licensed practitioner of the healing arts employed by or under contract with DHS; or (2) by a licensed 24-hour comprehensive residential program, group home or family-based program that is operated by or under contract with DHS.

3. Services are recommended by a licensed practitioner of the healing arts and delivered according to a plan of care.

4. Services are provided by or under the supervision of a licensed practitioner of the healing arts, including a licensed physician, licensed psychologist, licensed social worker, licensed registered nurse with training or experience in psychiatric nursing, licensed marriage and family therapist, licensed professional counselor, or licensed social service worker practicing within the scope of their license in accordance with Title 58 of the Utah Code Annotated 1953, as amended.

SERVICES PROVIDED BY LICENSED PRACTITIONERS - PSYCHOLOGISTS

LIMITATIONS

Services provided by licensed independent psychologists are limited to psychological evaluation, testing, and individual and group therapy for Medicaid eligibles who are eligible for EPSDT services.

FAMILY PLANNING SERVICES AND SUPPLIES

DEFINITION

Family planning services means diagnostic, treatment, drugs, supplies, devices, and related counseling in family planning methods to prevent or delay pregnancy. Family planning services are provided by or under the supervision of a physician for individuals of childbearing age, including minors who are sexually active.

LIMITATIONS

The following services are excluded from coverage as family planning services:

1. Experimental or unproven medical procedures, practices, or medication.

2. Surgical procedures for the reversal of previous elective sterilization, both male and female.

3. In-vitro fertilization.

4. Artificial insemination.

5. Surrogate motherhood, including all services, tests, and related charges.

6. Abortion services, except as covered under ATTACHMENT 3.1-a, (Attachment #5a).

7. Except for item 6 above, the Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PHYSICIAN SERVICES

LIMITATIONS

1. Supervision by a Physician

   Physician's services must be personally rendered by a physician licensed under state law to practice medicine or osteopathy, or by an individual licensed to serve the health care needs of a practice population under a physician's supervision.

   a. "Physician Supervision" means:

      The critical observation and guidance of medical services by a physician of a non-physician's activities to assure that the health, safety and welfare of patients is not compromised.

   The acceptable standard of supervision is availability by telephone when the physician maintains written protocols embodying care standards and supervisory procedures along with the Delegation of Services Agreement maintained at the practice site. Medical records must have sufficient documentation signed by the physician to reflect active participation of the physician in supervision and review of services provided by staff under supervision.

   b. "Direct Supervision" means:

      The physician must be present and immediately available to render assistance and direction through the time persons under supervision are performing services.

   When licensure laws, policy, education protocols, coding definitions, or service being provided require "Direct Supervision", the acceptable standard of supervision is availability in the facility, not necessarily within the same room, but within 10 minutes of reaching the person being supervised to provide assistance, consultation or direct care. Medical records must have sufficient documentation signed by the physician to reflect presence and participation of the physician in direct supervision.

PHYSICIAN SERVICES (Continued)

LIMITATIONS (Continued)

2. Psychiatric services are specialty medical services, and when provided in a private physician's office, shall be provided by the private physician. Charting and documentation must reflect the physician's provision of care.

   Non-physician counseling services are not a benefit of the Medicaid program except as authorized by policy for approved programs providing psychiatric care and treatment for individuals under 21 years of age.

3. Psychiatric services are specialty medical services, and when provided in a group practice or private clinic setting, must be provided, documented, and billed by the providing physician.

   Charting and documentation must clearly show that all services were personally provided.

4. Abortion services, except as covered under ATTACHMENT 3.1-A, (Attachment #5a).

PHYSICIAN SERVICES (Continued)

LIMITATIONS (Continued)

5. Admission to a general hospital for psychiatric care by a physician is limited to those cases determined by established criteria and utilization review standards to be of a severity and intensity that appropriate service cannot be provided in any alternative setting.

6. Inpatient hospital care for treatment of alcoholism and/or drug dependency will be limited to acute care for detoxification only.

7. Service not actually furnished to a client because the client failed to keep a scheduled appointment will not be covered by Medicaid.

8. Procedures determined to be cosmetic, experimental, or of unproven medical value are non-covered services.

9. Organ transplant services will be limited to those procedures for which selection criteria have been approved and documented in ATTACHMENT 3.1-E.

10. Selected medical and surgical procedures are limited to designated place of service. An approved list will be maintained in the Medicaid Physician Provider Manual.

11. Cognitive services: the diagnostic/treatment process including, but not limited to, office visit, hospital visits, and related services, are limited to one service each day per provider.

12. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
    a. that the proposed services are medically appropriate; and
    b. that the proposed services are more cost effective that alternative services.

13. The Division shall impose a co-payment for each physician visit, maximum of one per date of service, when a non-exempt Medicaid client, as designated on his Medicaid card, receives the physician service. The Division shall limit the out-of-pocket annual expense to $100 per client. These amounts are designated in R414-10-6.
    a. The Division shall deduct the co-pay amount from the reimbursement paid to the physician provider, up to the annual maximum.
    b. The provider should collect the co-pay amount from the Medicaid client for each visit requiring a co-payment.
    c. There are categories of Medicaid clients who are exempt from the co-payment requirement as designated in R414-10-6.
    d. Services rendered for family planning purposes are exempt from the co-payment requirement.

ABORTION SERVICES

DEFINITION

Abortion means all procedures performed for the purpose of terminating a pregnancy. Abortion does not include removal of a dead unborn child.

LIMITATIONS

Abortions procedures are limited to:

1. Those where the pregnancy is the result of an act of rape or incest; or

2. A case with medical certification of necessity where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

MEDICAL OR SURGICAL SERVICES FURNISHED BY DENTISTS

LIMITATIONS

1. A list of approved procedure codes for dentists and oral maxillofacial surgeons will be maintained in the Medicaid Dental Provider Manual. Certain medical and surgical procedures not reimbursable to physicians shall neither be reimbursable to dentists or oral maxillofacial surgeons.

2. Only dentists having a permit from the Division of Occupational and Professional Licensing may administer general anesthesia. The dentist administering the anesthesia may not also render the procedure.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PODIATRIST SERVICES

LIMITATIONS

Podiatrist services to non-pregnant adults age 21 years and older are limited to basic podiatrist services to prevent conditions that might lead to foot amputations.

1. Examination, treatment, and/or surgical procedures that are not limited to the area of the human foot. (Utah Code Annotated Vo. III, 58-5-1 through 58-5-15).
2. Routine foot care as described in 42 CFR 405.310(1) and noted in Podiatry Manual, Scope of Service.
3. Treatment of subluxation or Pes Planus as defined in 42 CFR 405.310(1) and noted in Podiatry Manual, Scope of Service.
4. Cutting or trimming nails, corns, warts, callouses for any patient who does not have arteriosclerosis, or Buerger's Disease, or diabetes.
5. Massages of the foot or adjoining structures.
6. Physical therapy services or procedures performed by a podiatrist.
7. Procedures performed in behalf of any patient that are not determined to be medically necessary and appropriate as determined by audit or post payment review.
8. General anesthesia administered by a podiatrist.
9. Amputation of the foot by a podiatrist.
10. Prosthetic devices except as defined in ATTACHMENT 3.1-A and 3.1-B, (Attachment #12c) of the Utah State Plan for Medicaid.
11. Orthotics, arch supports, foot pads, metatarsal head appliances, foot supports, "cookies", or other personal comfort items and services.
12. CPT-4 procedure codes except those describing service appropriate for podiatrists and listed in the Physician Manual, Podiatry Scope of Service and Index Section 7 and Appendix A.
13. J Codes (injection procedures) except those describing services appropriate for podiatrists and listed in the Physician Manual, Podiatry Scope of Services and Index 7 and Appendix A.
14. Laboratory procedures except those specified in the Physician Manual, Podiatry Scope of Service as appropriate for podiatrists to perform and for which the required equipment is available in the podiatrist's private office.
15. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:
    a. that the proposed services are medically appropriate; and
    b. that the proposed services are more cost effective than alternative services.

PODIATRIST SERVICES (Continued)

LIMITATIONS (Continued)

16. The Division shall impose a co-payment for each podiatrist visit, maximum of one per date of service, when a non-exempt Medicaid client, as designated on his Medicaid card, receives the podiatrist service. The Division shall limit the out-of-pocket annual expense to $100 per client. These amounts are designated in R414-11-10.
    a. The Division shall deduct the co-pay amount from the reimbursement paid to the podiatrist provider, up to the annual maxim.
    b. The provider should collect the co-pay amount from the Medicaid client for each visit requiring a co-payment.
    c. There are categories of Medicaid clients who are exempt from the co-payment requirements as designated in R414-11-10.
    d. Services rendered for family planning purposes are exempt from the co-payment requirement.

OPTOMETRIST SERVICES

SERVICES

1. Optometrist services to non-pregnant adults ages 21 years and older are not covered.

2. Optometrist services include the examination, evaluation, diagnosis and treatment of visual deficiency; removal of a foreign body; and prescription of corrective lenses by providers qualified to perform these services.

LIMITATIONS

The following services are excluded from coverage as Medicaid benefits:

1. Vision training;

2. Pathology services, as specified in the optometry license;

3. Separate charges for fitting, measurement of facial characteristics, writing the prescription or order, and final adjustments or office calls, when providing eye glasses or contact lenses.

4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

SERVICES PROVIDED BY LICENSED CHIROPRACTORS

LIMITATIONS

1. Services provided by licensed chiropractors are limited to treatment of the spine by means of manual manipulation, which includes x-rays of the spine. Services not related to spinal manipulation are not a benefit.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

SERVICES PROVIDED BY LICENSED PRACTITIONERS - PSYCHOLOGISTS

LIMITATIONS

Services provided by licensed independent psychologists are limited to:

1. Psychological evaluation and testing for Medicaid eligibles who:

   a. Exhibit mental retardation, developmental disability, or related condition; or

   b. Are victims of sexual abuse as documented in a report to the Department of Social Services; or

   c. Are eligible for EPSDT services.

2. Individual and group therapy for Medicaid eligibles who:

   a. Are victims of sexual abuse as documented in a report to the Department of Social Services; or

   b. Are eligible for EPSDT services.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES

DEFINITION

Home Health Services are part-time intermittent health care services, based on medical necessity, provided to eligible persons in their place of residence when the home is the most appropriate setting consistent with the clients's medical needs. Home health services are provided by a public or private state licensed, Medicare certified home health agency. Home Health Service is based on physician order and plan of care.

Two levels of Home Health Service are covered and identified by specific code.

1. Skilled Home Care includes nursing service as defined in the State Nurse Practice Act; home health aide service; and medical supplies, equipment and appliances suitable for use in the home.

   Physical therapy or speech pathology services are optional home health service under the skilled level of care. When such therapy services are approved as covered home health service, the service must be provided by qualified, licensed therapists through employment or contractual arrangement made by the Home Health Agency.

2. Supportive, Maintenance Home Health Care

   Recipients served in their place of residence through a long term maintenance program are those who have a medical condition which has stabilized, but who demonstrate continuing health problems requiring minimal assistance, observation, teaching or follow-up. This assistance can be provided by a certified home health agency through the knowledge and skill of a licensed practical nurse (LPN) or a home health aide under specific written instructions and periodic supervision by a registered nurse. Supportive maintenance home health care is based on physician order and plan of care and provided in the home when the home is the most appropriate setting consistent with the client's medical needs.

HOME HEALTH SERVICES (Continued)

LIMITATIONS

The following services are excluded from coverage:

1. Home Health Service which is not ordered and directed by a physician, written in an approved plan of care, and reviewed and recertified by a physician every two calendar months, a time limitation not to exceed 60 days.

2. Home Health Service which is not provided or supervised by a registered nurse employed by a home health agency and provided by the appropriate professional in the patient's place of residence.

3. Home Health Service provided to a patient capable of self-care.

4. Housekeeping or homemaking services.

5. Occupational therapy.

6. Physical therapy and/or speech pathology services not included in the plan of care and/or not provided by a qualified, licensed therapist.

7. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - HOME HEALTH AIDE

LIMITATIONS

1. Home health aide services must be provided by a Home Health Agency through an established plan of care.

2. Home health aide services must be provided under specific written instruction and supervised by a registered nurse.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES

LIMITATIONS

Supplies, equipment (durable or disposable), and appliances are provided to Medicaid recipients who reside at home. Services are provided in accordance with 42 CFR 440.70(b)(3) and with established Medicaid policy covering medical supplies.

The following items are excluded from coverage as benefits of the Medicaid program:

1. First aid supplies other than those used for post surgical need, accidents, decubitus treatment, and long-term dressing.

2. Surgical stocking if ordered by a non-physician.

3. Syringes in excess of 100 per month.

4. Beds, when the recipient is not bed confined.

5. Variable height beds.

6. Two oxygen systems unless the physician has specifically ordered portable oxygen for travel to practitioners.

7. Oxygen systems provided more frequently than monthly.

8. Spring-loaded traction equipment.

9. Wheelchairs, unless the recipient would be bed or chair confined without the equipment.

   Wheelchairs, attachments, and other adaptive equipment for addition to wheelchairs, require prior authorization and review. Physician order and documentation must show that established criteria have been met, documenting the medical need for use of a wheelchair to promote maximum reduction of physical disability and support of the patient at the best functional level.

10. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

    a. that the proposed services are medically appropriate; and

    b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - PHYSICAL THERAPY SERVICES

LIMITATIONS

1. Physical therapy and/or physical medicine service provided by a home health agency must be prescribed by a physician and included in the plan of care. Physical therapy services are limited to those provided by a qualified, licensed physical therapist and must follow all regulations governing physical therapy service.

2. Treatment must follow written plan of care, and there must be an expectation that the patient's medical condition, under treatment, will improve in a predictable period of time.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

HOME HEALTH SERVICES - SPEECH PATHOLOGY SERVICE

LIMITATIONS

1. Speech pathology service provided by a home health agency must be prescribed by a physician and included in the plan of care. Speech pathology services are limited to those provided by a qualified, licensed speech therapist, and must follow all regulations governing speech pathology services.

2. Treatment must follow a written plan of care, and there must be an expectation that the patient's medical condition, under treatment, will improve in a predictable period of time.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PRIVATE DUTY NURSING

LIMITATIONS

1. Private duty nursing services will be provided:

   a. To ventilator-dependent individuals who meet established criteria; and

   b. In the individual's home, in order to prevent prolonged institutionalization. The service will be based on physician order and a written plan of care specific to needs of the individual, reviewed and recertified every 60 days; and

   c. For a period of time essential to meet medically necessary care needs and develop confidence in family care givers. Private duty service needs are expected to decrease over time.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

CLINIC SERVICES

LIMITATIONS

1. End Stage Renal Dialysis

   Limited to medically accepted dialysis procedures, such as peritoneal dialysis (CAPO, CCPO and IPO) or hemodialysis for outpatients receiving services in free-standing State-licensed facilities, which are also approved under title XVIII.

2. Ambulatory Surgical Centers

   Scope of service is limited to ambulatory surgical procedures which are scheduled for non-emergency conditions.

3. Free Standing Birthing Clinics

   Limited to treatment during gestation, delivery and the normal postpartum period.

4. Alcohol and Drug Center

   Service limited to Methadone treatment at an approved center.

CLINIC SERVICES (Continued)

LIMITATIONS (Continued)

5. Maternal and Child Health (Title V Grantee) Clinics

   a. Maternal and Child Health Clinic services are covered benefits for EPSDT eligibles.

   b. Qualified providers include clinics under the direction of a licensed physician and operated or administered by the Title V grantee agency.

   c. The clinic scope of benefits includes preventative, diagnostic, therapeutic, rehabilitative, or palliative items or services, including early intervention services, provided by or under the direction of a licensed physician or dentist. Other providers of services include registered nurses, psychologists, dieticians, clinical social workers, audiologists, speech and language pathologists, occupational therapists, or physical therapists practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing (Utah Code Annotated, as amended 1953).

   d. All clinic services are provided under the direction of a physician according to a written plan of care that is reviewed periodically by the directing physician.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

DENTAL SERVICES

SERVICE

1. Dental services to non-pregnant adults age 21 years and older are for emergency services only and are limited to x-rays and extractions to alleviate pain and infection.

2. Dental service includes diagnostic, preventive and restorative procedures.

LIMITATIONS

1. Dental services are limited to those services for the prevention and abatement of decay and restoration of dental health.

   Excluded services include:

   a. Orthodontics or surgery for orthodontic purposes;

   b. Fixed bridges, osseo-implants, sub-periosteal implants, ridge augmentation, transplants, or replant;

   c. Pontic services, vestibuloplasty, occlusal appliances, or osteotomies;

   d. Study models or diagnostic casts;

   e. Treatment of temporomandibular joint syndrome, its prevention or sequelae, subluxation, therapy, arthrotomy, meniscectomy, or condylectomy;

   f. Dental examination or prophylaxis performed more frequently than twice per calendar year by a provider for a client.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PHYSICAL THERAPY SERVICES

SERVICES

1. Physical therapy services to non-pregnant adults ages 21 years and older are not covered.

2. Physical therapy services include:

   a. treatment by the use of exercise, massage, heat or cold, air, light, water, electricity, or sound in order to correct or alleviate a physical or mental condition or prevent the development of a physical or mental disability; or

   b. the performance of tests of neuromuscular function as an aid to diagnosis or treatment.

   c.

LIMITATIONS

1. Physical therapy services will be provided for rehabilitation only. Therapy for the purpose of maintenance is not a covered Medicaid benefit. Physical therapy service must be based on physician order, follow a written plan of care, and be specific for the patient's diagnosis.

2. Physical therapy for stroke patients must be initiated within sixty (60) days following the stroke and may continue only until the expected, reasonable level of function is restored.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

OCCUPATIONAL THERAPY SERVICES

SERVICES

Occupational therapy services to non-pregnant adults age 21 years and older are not covered.

Occupational therapy services include therapeutic rehabilitative and preventative services for individuals who are limited by physical injury (traumatic brain injury, spinal cord injury and hand injury), illness (CVA), congenital anomalies or developmental disabilities causing neurodevelopmental deficits such as cerebral palsy.

LIMITATIONS

Occupational therapy services will be provided for rehabilitation only. Therapy for the purpose of maintenance is not a covered Medicaid benefit. Occupational therapy service must be based on physician order, follow a written plan of care, and be specific for the patient's diagnosis.

Occupational therapy for CVA patients must be initiated within 90 days following the stroke, and my continue only until the expected, reasonable level of function is restored.

Occupational therapy for CVA patients must be initiated within 90 days following the stroke, and may continue only until the expected, reasonable level of function is restored.

SPEECH PATHOLOGY SERVICES

SERVICES

1. Speech pathology services to non-pregnant adults age 21 years and older are not covered.

2. Speech pathology services include examination, diagnosis, and therapy to correct or ameliorate speech-language disorders, abnormalities, behavior or their effects.

LIMITATIONS

1. One speech evaluation per client per year is a covered service.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

AUDIOLOGY SERVICES

SERVICES

1. Audiology services to non-pregnant adults age 21 years and older are not covered.

2. Audiology services include preventive, screening, evaluation, diagnostic services and the provision of hearing aids.

LIMITATIONS

1. Hearing aids must be guaranteed by the manufacturer for one year or more;

2. Charges for the return of a hearing aid (within 60 days) when the physician or audiologist determines that the aid does not meet specifications, and requests a change.

3. Separate charges for initial ear mold, fitting, conformity evaluation, testing batteries, and instruction recipients.

4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PRESCRIBED DRUG SERVICES

LIMITATIONS

1. Drug Efficacy Study Implementation Project Drugs (DESI Drugs) as determined by the FDA to be less-than-effective are not a benefit of the Medicaid program.

   Other drugs and/or categories of drugs as determined by the Utah State Division of Health Care Financing and listed in the Pharmacy Provider Manual are not a benefit of the Medicaid program.

2. Generically equivalent drugs, approved by the FDA and listed in the Pharmacy Provider Manual, are a benefit of the Medicaid program.

3. Over-the-counter (OTC) drugs are limited to those drugs approved for use upon the recommendation of the Utah State Division of Health Care Finance and listed in the Pharmacy Provider Manual.

4. Immunosuppressive drugs will be limited to use with covered transplants.

5. The Division shall impose a copayment for each prescription filled when a non-exempt Medicaid client, as designated on his Medicaid card, receives the prescribed medication. The Division shall limit the out-of-pocket monthly expense of the Medicaid client. These amounts are designated in R414-60 UAC.

   a. The Division shall deduct the copay amount from the reimbursement paid to the provider, up to the monthly maximum.

   b. The provider should collect the copayment amount from the Medicaid client for those prescriptions requiring a copayment.

   c. There are categories of Medicaid clients who are exempt from the copayment requirement, as designated in R414-60 UAC.

   d. Pharmaceuticals prescribed for family planning purposes are exempt from the copayment requirement.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

DENTURE SERVICES

SERVICE

a. Denture services to non-pregnant adults age 21 and older are excluded.

b. Denture services refers to the fabrication and placement of a complete or partial denture in either arch.

c. Initial placement includes the relining to assure the desired fit.

LIMITATIONS

1. Denture services are excluded as an optional service based on 42 CFR 440.210, 440.220, and 440.225 except for pregnant adults age 21 and older.

PROSTHETIC DEVICES

Prosthetic devices mean replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by the State law to:

1. Artificially replace a missing portion of the body;

2. Prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3. Support a weak or deformed portion of the body.

LIMITATIONS

The following services are excluded from coverage as a benefit of the Medicaid program:

1. Shoes, orthopedic shoes or other supportive devices for the feet, except when shoes are integral parts of leg braces or a prosthesis.

2. Shoe repair except as it relates to external modification of an existing shoe to meet a medical need, e.g., leg length discrepancy requiring a shoe “build-up” of one inch or more.

3. Personal comfort items and services. Comfort items include, but are not limited to, arch supports, foot pads, “cookies” or accessories, shoes for comfort, or athletic shoes.

4. Manufacture, dispensing or services related to orthotics of the feet.

5. Internal modifications of a shoe, except when supported by documentation of medical necessity.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

PROSTHETIC AND ORTHOTIC SERVICES
(BRACES, ARTIFICIAL LIMBS, AND/OR PARENTERAL/ENTERAL SUPPLIES)

"Prosthetic devices" means replacement, corrective or supportive devices prescribed by a physician or other licensed practitioner of the healing arts within the scope of his practice as defined by State law to:

1. Artificially replace a missing portion of the body;

2. Prevent or correct physical deformity or malfunctions (including promotion of adaptive functioning); or

3. Support a weak or deformed portion of the body.

LIMITATIONS

The following items are excluded from coverage as benefits of the Medicaid program:

1. Any support items that could be classified as a corset, even those that have metal or wire supports;

2. "Test" equipment;

3. Any item provided to nursing home recipients which have been specifically restricted in the index in the Medical Supplies Provider Manual;

4. The provision of two monaural hearing aids instead on one binaural aid;

5. Rental of a hearing aid in excess of three months;

6. Nutrients used as food supplements. They are a Medicaid benefit only as total nutrition;

7. Baby formula such as Similac, Enfamil, or Mull-Soy.

8. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

EYEGLASS SERVICES

SERVICES

1. Eyeglass services for non-pregnant adults ages 21 and older are not covered.

2. Eyeglass services include providing glass lenses with frames, contact lenses and other aids to vision that are prescribed by a physician skilled in diseases of the eye or by an optometrist.

LIMITATIONS

The following services are excluded from coverage:

1. Oversize, exclusive, or specialty lenses;

2. Extended wear contact lenses;

3. Sun glasses or dark tint;

4. Any frame other than basic metal or plastic;

5. Lenses that are not for indoor/outdoor, day/night use.

6. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

DIAGNOSTIC AND REHABILITATIVE SERVICES

LIMITATIONS

Diagnostic and rehabilitative mental health services are limited to medically necessary services designed to promote the client's mental health, reduce the client's mental disability, and restore the client to the highest possible level of functioning.

1. Services include diagnostic evaluation, psychological testing, individual therapy, group therapy, medication management, day treatment and skills development services.

   Skills development services means rehabilitative services designed to (1) assist individuals to develop competence in basic living skills in the areas of food planning, shopping, food preparation, money management, mobility, grooming, personal hygiene and maintenance of the living environment, and appropriate compliance with the medication regimen; (2) assist individuals to develop community awareness, and (3) assist individuals to develop social skills including teaching communication and socialization skills and techniques. Skills development services may also include supportive counseling directed toward eliminating psycho social barriers that impede the individual's ability to function successfully in the community.

2. Diagnostic and rehabilitative mental health services are covered benefits when provided by or through a comprehensive mental health treatment center licensed in accordance with Sections 63-35a-1 through 16, Utah Code Annotated 1953, as amended.

3. Services are recommended by a licensed practitioner of the healing arts and delivered according to a plan of care.

DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

LIMITATIONS (Continued)

4. Services are provided by or under the supervision of a licensed practitioner of the healing arts, including a licensed physician, licensed psychologist, licensed social worker, registered nurse with training or experience in psychiatric nursing, licensed social service worker, or licensed marriage and family therapist practicing within the scope of their license in accordance with Title 58 of the Utah Code Annotated 1953, as amended.

Telehealth mental health is a complementary method of delivering traditional mental health services. The telehealth mode of delivery is reserved for rural clients where distance and travel time create difficulty with access to needed psychiatric and other mental health therapy services. Telehealth is designed to improve client access to mental health care in rural areas of Utah.

Limitations

1. Telehealth mental health services are limited to clients residing in rural areas of Utah.

2. Telehealth mental health services are limited to a telehealth site that provides audio and video communication between the provider and the client.

3. Telehealth mental health services are limited to psychiatric evaluations, on-going physician medication management services, and individual therapy services. Preauthorization for telehealth mental health services is not required.

4. Compliance with the Utah Health Information Network (UHIN) standards for telehealth will be maintained.

DIAGNOSTIC AND REHABILITATIVE SERVICES (Continued)

LIMITATIONS (Continued)

5. Telehealth mental health services will be billed to Medicaid by the comprehensive mental health treatment center in the same way as face-to-face mental health services are billed. Two additional modifiers, “GT” and “TR”, will be added to the mental health procedure code indicating the delivery mode (telehealth) and whether a presenting provider was utilized during service.

6. The “GT” modifier will be used with the mental health procedure code to indicate that the mental health service was provided through the telehealth mode of delivery. This modifier is required to monitor utilization and evaluate the financial impact of the project. The “TR” modifier will also be used with the mental health procedure code to indicate a presenting provider was present to assist the client during the telehealth mental health service. The role of the presenting provider is to assist mentally ill clients in understanding and successfully communicating with the consultant during a telehealth service. This modifier will provide data indicating how often a presenting provider is needed to ensure successful communication (between) the consultant and the client.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

LIMITATIONS

1. Preventive services provided by the State Poison Control Center, through the Division of Family Health Services, are covered benefits for Medicaid recipients.

2. Services are provided by a physician or pharmacist practicing within the scope of their license in accordance with Title 58, Occupational and Professional Licensing, of the Utah Code Annotated 1953, as amended.

3. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

OTHER DIAGNOSTIC, SCREENING, PREVENTIVE AND REHABILITATIVE SERVICES

LIMITATIONS

Diagnostic and Rehabilitative Substance Abuse Treatment Services

Diagnostic and rehabilitative substance abuse treatment services are covered benefits when provided by or through a substance abuse treatment program under contract with a Local County Comprehensive Substance Abuse Plan licensed in accordance with Section 62A-2-101-116, Utah Code Annotated, as amended.

1. Diagnostic and rehabilitative services are limited to medically necessary services designed to eliminate the client's substance abuse, reduce or eliminate maladaptive or hazardous behaviors, and restore the client to the highest possible level of functioning. These services may also be provided to the client's children to reduce their risk of becoming substance abusers.

2. Services include evaluation, psychological testing, medication management, individual and group therapy, individual and group substance abuse counseling, and skills development services.

3. Services must be recommended by a licensed physician, or other practitioner of the healing arts, within the scope of his practice under state law, and delivered according to a plan of care that is reviewed periodically in accordance with the Utah State Division of Substance Abuse policy regarding treatment plan reviews.

4. Services may be provided by qualified providers including licensed physicians, licensed psychologists, licensed certified or clinical social workers, licensed advanced practice registered nurses, licensed marriage and family therapists, licensed professional counselors, licensed registered nurses, licensed social service workers, or licensed substance abuse counselors, as defined in Title 58, Utah Code Annotated, or by other staff trained to work with substance abuse disorders who are working under the supervision of a licensed practitioner.

DIAGNOSTIC AND PREVENTIVE SERVICES

DEFINITION

Telehealth Home Care for the Diabetic Patient

Telehealth home care is a complementary method of delivering traditional home health care through an electronic medium. It does not replace onsite home health care, but provides a means of monitoring and counseling patients. Understanding disease progression, and acquisition of the monitoring skills to prevent complications, disease progression, and disability will enable the individual to take responsibility for a healthy lifestyle that promotes quality mental and physical health.

LIMITATIONS

1. Telehealth home care is limited to home-bound patients with diabetes living in rural areas of Utah.

2. Telehealth home care consultations for this program are limited to 20-30% of home health care visits preauthorized by Utilization Management staff review. Ten to 12 home health care visits are usually authorized by Utilization Management for a patient. Telehealth visits for teaching and follow-up of diabetic patients will be included within these preauthorized home health care visits.

3. Diabetic patients eligible for participation in Telehealth must be able to physically and mentally use Telehealth equipment and have a desire to participate. The patient wishing to participate in Telehealth home care who is unable to use the Telehealth equipment may be included in the pilot project when there is a full time care giver consistently available who wishes to assist the patient with Telehealth.

4. Documentation of the diabetic patient condition and plan of care for follow-up must clearly indicate to the prior authorization unit that hands-on assessment is not required and/or the home health nurse determines that the patient does not meet severity of illness criteria or have complicating conditions that might limit patient inclusion in the Telehealth home care project.

5. Diabetes Telehealth home care is limited to monitoring and counseling activities provided by a registered nurse. A dietician may provide dietary counseling with physician referral. Patient-initiated anxiety calls will be the responsibility of the home health agency.

6. Compliance will be maintained with the Utah Health Information Network (UHIN) standards for Telehealth.

DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

Telehealth Services for Children with Special Health Care Needs

Telehealth is a complementary method of delivering traditional physician and dietary consultation. The Telehealth mode of delivery is reserved for rural clients where distance and travel time create difficulty in access to pediatricians, physician specialists, and dieticians. This Telehealth program is designed to improve health care access for Special Health Care Needs Children residing in rural areas of Utah. Special Health Care Needs Children are defined as children who have, or are at increased risk for, disabilities from chronic physical, developmental, behavioral, or emotional conditions.

LIMITATIONS

1. Telehealth care is limited to Special Health Care Needs Children residing in rural areas of Utah.

2. The Telehealth sites chosen to participate in services for special health care needs children have the necessary technology in place. Other rural sites will be added as soon as the technology becomes available. Audio and video communication between the consulting provider and the patient will require linkage between the University of Utah Telemedicine site and Telehealth sites within the rural health clinic.

3. Scheduling of Telehealth sessions for Children with Special Health Care Needs will be limited to rural health department clinics. Preauthorization is not required.

4. Consulting providers will be limited to physicians and dieticians for this program. Nutritional assessments and counseling will be provided by certified dieticians within their scope of practice and state license. Counseling services of the dietician will be provided as medically necessary to address inappropriate diet, feeding problems, alterations in growth, risks related to drug-nutrient interaction, and metabolic disorders. Dietary counseling sessions will be limited to five sessions per calendar year.

5. Compliance will be maintained with the Utah Health Information Network (UHIN) standards for Telehealth.

DIAGNOSTIC, SCREENING, PREVENTIVE, AND REHABILITATIVE SERVICES

Telehealth Services for Children with Special Health Care Needs (continued)

6. The modifier GT will be used to indicate that the health care services were provided by the Telehealth mode of delivery. This modifier is required to monitor and evaluate the financial impact of this project.

7. The TR modifier will be used to indicate a presenting provider was in attendance at the local health department. This modifier will provide data indicating the number of times the presence of a presenting provider was required for a Telehealth session to enhance physician assessment of the patient for the consulting provider.

8. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternate services.

OTHER DIAGNOSTIC AND PREVENTIVE SERVICES

Diabetes Self Management Training

Diabetes Self Management is an educational process to teach the individual how to successfully manage and control diabetes. The training will increase the individual's understanding of disease progression and teach monitoring skills to prevent complications, disease progression, and disability. As a result of the training the individual will be able to identify potential diabetes-related problems, establish achievable self-care goals, and take responsibility for maintaining a healthy lifestyle that promotes quality mental and physical health. The program Coordinator will be responsible for maintaining ongoing open communication with the patient's physician. The Coordinator will inform the physician of the patient's progress, compliance, or issues of concern identified while the patient's training is in progress. Evaluation of the patient training will occur with each session, at the conclusion of training, and the program Coordinator will complete follow up with the patient several months after the training. Issues or concerns will be communicated directly to the physician.

LIMITATIONS

1. Diabetes self management is limited to a maximum of ten hours of outpatient service. Instructors eligible to provide diabetes self management training will include Utah licensed registered nurses and certified dieticians who are eligible under their scope of practice to provide counseling for patients with diabetes and monitor patient compliance with the plan of care.

2. Diabetes self management is limited only to the program that meets the National Diabetes Advisory Board standards (NDAB) and is recognized by the American Diabetes Association (ADA) or certified by the Utah Department of Health.

3. Diabetes self management is limited to that certified by the physician, under a comprehensive plan as essential to ensure successful diabetes management by the individual patient.

4. Diabetes self management is limited only to the training presented in a certified program that meets all of the NDAB standards and is recognized by the American Diabetes Association (ADA) or certified by the Utah Department of Health.

5. Diabetes self management includes group sessions, but must allow for direct face-to-face interaction between the educator and the patient, to provide opportunity for questions and personal application of learned skills.

6. Diabetes self management must be sufficient in length to meet the goals of the basic comprehensive plan of care. Individual sessions must be sufficient in number and designed to meet the medical and instructional needs of the individual.

OTHER DIAGNOSTIC AND PREVENTIVE SERVICES

Diabetes Self Management Training (continued)

7. Repeat of any or all of a diabetes self management program is limited to new conditions or alteration of health status that warrants the need for new training.

8. Home Health Agency participation in diabetes self management is limited to providing service to the homebound patient, who is receiving other skilled services in the home based on physician order and plan of care.

9. Diabetes self management service provided by a home health agency must be provided only by a licensed RN or dietitian certified or recognized by an American Diabetes Association (ADA) program or Utah Department of Health.

SERVICES FOR INDIVIDUALS AGE 65 OR OLDER
IN INSTITUTIONS FOR MENTAL DISEASE (IMD)

LIMITATIONS

1. Services for individuals age 65 or older in an institution for mental disease are a benefit of the Medicaid program in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of Utah Administrative Code R432-101. Services must be provided under the direction of a physician.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

INTERMEDIATE CARE FACILITY SERVICES

Intermediate care facility services (other than services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

In accordance with section 1919(f)(7) of the Act, personal hygiene items and services may be charged to the patient's personal needs fund. The following limitations apply.

LIMITATIONS

1. The following personal hygiene items and services may, at the request of the patient or the patient's advocate, be charged to the patient's personal needs fund:

   a. Personal grooming services such as cosmetic hair and nail care;

   b. Personal laundry services;

   c. Specific brands of shampoo, deodorant, soap, etc., requested by the patient or patient's advocate and not ordinarily supplied by the nursing home as required in 2(a) and (b) below.

2. In accordance with State Plan amendment 4.19-D, Nursing Home Reimbursement, the following personal hygiene items and services may not be charged to the individual's personal needs fund:

   a. Items specific to a patient's medical needs, such as protective absorbent pads (such as Chux), prescription shampoo, soap, lotion.

   b. General supplies needed for personal hygiene such as toothpaste, shampoo, facial tissue, disposable briefs (diapers), etc.

INPATIENT PSYCHIATRIC FACILITY SERVICES
FOR INDIVIDUALS UNDER 21 YEARS OF AGE

LIMITATIONS

1. Inpatient psychiatric services for individuals under age 21 are a benefit of the Medicaid program only for care and treatment provided under the direction of a physician in a hospital licensed as a Specialty Hospital - Psychiatric, under the authority of the Utah Administrative Code R432-101, 1992 as amended.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

SCOPE OF SERVICES
INTENSIVE SKILLED CARE (NURSING HOMES)

In order to care for the more acutely ill patient being admitted to Skilled Nursing Facilities from hospitals, a new level of care will be adopted.

Patients admitted requiring nursing care, rehabilitation and other services over and/or above usual circumstances will be classified as Intensive Skilled.

The Health Facilities Pre-admission Unit will assess patients for this category of service. Classification in this area will be based on nursing home, patient assessment, length of stay and services required to meet individual patient's needs.

Health Care Financing will contract with all nursing homes admitting Intensive Skilled Care patients for specialized services meeting individual patient's needs.

If necessary, patients in this category should have available rehabilitative services to assist in restoring to maximum potential.

PERSONAL CARE SERVICES IN A RECIPIENT'S HOME

LIMITATIONS

1. Personal care services are covered benefits when provided by a home health agency licensed in accordance with Utah Code Annotated, Title 26, Chapter 21. Services are delivered by a personal care aide or a home health aide (performing only personal care level tasks) who has obtained a certificate of completion from the State Office of Education, or a licensed practical nurse, or a licensed registered nurse. Pesonal Care services are prescribed by a physician and are provided under the supervision of a registered nurse. Personal care services are not provided by a member of the recipient's family.

2. Personal care services are covered benefits only for recipients who (a) receive services in their place of residence which is not an institution; (b) do not receive Medicaid home health aide services on the same day they receive personal care services.

3. Personal Care Services are limited to 60 hours per month.

4. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

TB RELATED SERVICES TO TB INFECTED INDIVIDUALS

LIMITATIONS

1. Directly Observed Therapy (DOT)/Behavior Modification services will provide for directly observed administration of tuberculosis medication, which means the direct observation of patients swallowing anti-tuberculosis medication. Recipients must be assessed as medically appropriate for DOT based upon the recipient's risk of non-adherence to medication regimen necessary to cure and prevent the spread of an infectious, potentially fatal disease which may not respond to conventional therapies. Services shall be furnished five or more days per week, unless otherwise ordered by the physician in the recipient's plan of care. This service is provided in accordance with a therapeutic goal in the plan of care. The plan of care will include a behavior modification program to aid in establishing a pattern of adherence to treatment. The behavior modification program will be developed on an individual basis based on the patients history of non-compliance. Daily monitoring of adherence and behavior modification is necessary to ensure completion of the prescribed drug therapy, since inconsistent or incomplete treatment is likely to lead to drug resistance or reactivation, posing a major threat to the public health. DOT includes security services designed to encourage completion of medically necessary regimens of prescribed drugs by certain non-compliant TB infected individuals on an outpatient basis.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

EXTENDED SERVICES TO PREGNANT WOMEN

The following major categories of service are available as pregnancy related or postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

1. Inpatient Hospital Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #1)

2. Outpatient Hospital Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #2)

3. Family Planning Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #4.c)

4. Physician Services
   Limitations identified in ATTACHMENT 3.1-A (Attachment #5)

5. Home Health Visits
   Limitations identified in ATTACHMENT 3.1-A (Attachment #20.b, page 3)

6. Medical Supplies and Equipment
   Limitations identified in ATTACHMENT 3.1-A (Attachment #7.c)

7. Prescription Drug Services
   Limited to treatment of pregnancy related conditions, complications, and family planning. Limited also to those limitations identified in ATTACHMENT 3.1-A (Attachment #12.a)

8. Certified Registered Nurse Midwife Services
   Limited to maternity cycle, i.e., pregnancy, labor, birth, and the immediate post-partum period which begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends.

9. Certified Pediatric and Family Nurse Practitioners
   Limitations identified in ATTACHMENT 3.1-A (Attachment #23)

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

The following services are being expanded beyond limitation for all groups described and the services are provided only for pregnant women.

A. Physician Services

Risk Assessment

Risk assessment is the systematic review of relevant client data to identify potential problems and plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contribute significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. The care plan for low risk clients incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation with an appropriate specialist, individualized counseling and services designed to address the particular risk factors involved. Risk assessment will be accomplished using the Utah Perinatal Record System or other formalized risk assessment tool. Consultation standards will be consistent with the Utah Medical Insurance Association guidelines.

Limited to two risk assessments during any 10-month period.

Prenatal Assessment Visit (Initial Visit Only)

The initial prenatal visit for a new patient with a confirmed pregnancy, providing an evaluation of the mental and physical status of the patient, an in-depth family and medical history, physical examination, development of medical data, and initiation of a plan of care.

Limited to one visit in any 10-month period, to be used only when patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because patient does not return.

Single Prenatal Visit (Visit Other Than Initial Visit)

A single prenatal visit for an established patient who does not return to complete care for unknown reasons. Initial assessment visit was completed, plan of care established, one or two follow-up visits completed but no follow through with additional return visits.

Limited to a maximum of three visits in any 10-month period, to be used outside of global service, only when the patient is lost to follow-up for any reason.

High Risk Pregnancy Care

High risk pregnancy as determined and reported through use of the formalized risk assessment tool shall be managed by physicians according to the Utah Medical Insurance Association guidelines. Additional reimbursement will be considered when criteria for high risk pregnancy care are met.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

B. Certified, Registered Nurse Midwife Services

Risk Assessment

Risk assessment is the systematic review of relevant client data to identify potential problems and plan for care. Early identification of high risk pregnancies with appropriate consultation and intervention contribute significantly to an improved perinatal outcome and lowering of maternal and infant morbidity and mortality. The care plan for low risk clients incorporates a primary care service package and additional services specific to the needs of the individual client. High risk care includes referral to or consultation with an appropriate specialist, individualized counseling, and services designed to address the particular risk factors involved. Risk assessment will be accomplished using the Utah Perinatal Record system or other formalized risk assessment tool. Consultation standards will be consistent with the Utah Medical Insurance Association guidelines.

Certified nurse midwives may care for some psycho socially or demographically high risk women according to written agreements with consulting physicians or admitting hospitals.

Limited to two risk assessments during any 10-month period.

Prenatal Assessment Visit (Initial Visit Only)

The initial prenatal visit for a new patient with a confirmed pregnancy, providing an evaluation of the mental and physical status of the patient, an in-depth family and medical history, physical examination, development of medical data, and initiation of a plan of care.

Limited to one visit in any 10-month period, to be used only when patient is referred immediately to a community practitioner because of identified risks or otherwise lost to follow-up because patient does not return.

Single Prenatal Visit (Visit Other Than Initial Visit)

A single prenatal visit for an established patient who does not return to complete care for unknown reasons. Initial assessment visit was completed, plan of care established, one or two follow-up visits completed, but no follow through with additional return visits.

Limited to a maximum of three visits in any 10-month period, to be used outside of global service, only when the patient is lost to follow-up for any reason.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

The following services are being added as certified registered nurse midwife services and provided only for pregnant women throughout pregnancy and up to the end of the month in which the 60 days following pregnancy ends.

Perinatal Care Coordination

Perinatal care coordination is the process of planning and coordinating care and services to meet individual needs and maximize access to necessary medical, psycho social, nutritional, educational, and other services for the pregnant women.

Prenatal and Postnatal Home Visits

Home visits can be included in the management plan of pregnant patients when there is a need to assess the home environment and implications for management of prenatal and postnatal care, to provide direct care, to encourage regular visits for prenatal care, to provide emotional support, to determine educational needs, to monitor progress, to make assessments, and to re-evaluate the plan of care.

Limited to no more than six visits during any 12-month period.

Group Prenatal/Postnatal Education

Classroom learning experience for the purpose of improving the knowledge of pregnancy, labor, childbirth, parenting and infant care. The objective of this planned educational service is to promote informed self care, to prevent development of conditions which may complicate pregnancy, and to enhance early parenting and child care skills.

Limited to eight units during any 12-month period. One unit is equal to one class at least one hour in length.

The following services are being added for specific providers. These services will be limited only to pregnant women throughout pregnancy and up to the end of the month in which the 60 days following the pregnancy occurs.

C. Licensed, certified social worker, clinical psychologist, marriage and family counselor services.

Prenatal and Postnatal Psycho social Counseling

Psycho social evaluation is provided to identify patients and families with high psychological and social risks, to develop a psycho social care plan and provide or coordinate appropriate intervention, counseling or referral necessary to meet the identified needs of families.

Limited to 12 visits in any 12-month period.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

D. Registered Dietitian Services

Nutritional Assessment/Counseling

All women are referred to the WIC program for nutritional assessment. Women with complex nutritional or related medical risk factors as determined in initial prenatal visits may require intensive nutrition education, counseling, monitoring and frequent consultation, and may receive service by referral from a physician, certified nurse midwife, or a family nurse practitioner to a registered dietitian.

Limited to 14 visits during any 12-month period.

E. Community Health Nurse Services

Perinatal Care Coordination.

Prenatal and Postnatal Home visits, as defined above in B, may be provided by the community health nurse.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the community health nurse.

F. Registered Nurse Services

Perinatal Care Coordination

Prenatal/Postnatal Home visits, as defined above in B, may be provided by the registered nurse.

G. Certified Family Nurse Practitioner Services

Perinatal Care Coordination

Risk Assessment, as defined above in B, may be provided by the certified family nurse practitioner.

Prenatal and Postnatal Home visits, as defined above in B, may be provided by the certified family nurse practitioner.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the certified family nurse practitioner.

Prenatal Assessment visit, as defined above in B, may be provided by the certified family nurse practitioner.

Single prenatal visits, as defined above in B, may be provided by the certified family nurse practitioner.

EXTENDED SERVICES TO PREGNANT WOMEN (Continued)

H. Health Educator Services

Perinatal Care Coordination may be provided by those meeting the established criteria.

Group Prenatal/Postnatal education, as defined above in B, may be provided by the health educator.

I. Social Worker Services

Perinatal Care Coordination may be provided by a licensed social service worker (SSW) who meets the established criteria.

Perinatal Care Coordination may be provided by a licensed certified social worker (LCSW) who meets the established criteria.

CERTIFIED PEDIATRIC AND FAMILY NURSE PRACTITIONERS

LIMITATIONS

1. Services provided by a licensed certified pediatric nurse practitioner (CPNP) or a licensed certified family nurse practitioner (CFNP) are limited to ambulatory, non-institutional services provided to the extent that licensed certified pediatric and family nurse practitioners are authorized to practice under state law.

2. The Agency may exceed the limitations on existing covered services to the extent allowed by law, if its medical staff determines:

   a. that the proposed services are medically appropriate; and

   b. that the proposed services are more cost effective than alternative services.

TRANSPORTATION SERVICES

LIMITATIONS

1. Coverage of optional transportation service is limited to the most reasonable and economical means of transportation necessary to secure medical examination and/or treatment for a recipient by a provider to whom a direct vendor payment can be made.

2. Travel expenses are limited to:

   a. Cost of transportation for recipient by approved means.

   b. A per diem not to exceed a maximum established by the State to be applied toward cost of meals and lodging when it is necessary for the recipient to remain away from home, outside of a medical facility while receiving approved treatment.

   c. Cost of transportation and per diem not to exceed a maximum established by the State, to be applied to cost of meals and lodging for one parent to accompany a child to receive approved services out-of-state when there is a need for the parent to receive instructions in meeting the medical needs of the child.

   d. Transportation costs and related travel expenses for an attendant to accompany a recipient for approved services only available out-of-state, when there is a justified medical need for an attendant. (A parent or a guardian can qualify as the attendant providing the individual can meet the existing medical need demonstrated by the patient.) Salary is included if the attendant is not a member of the patient's family.

      These services are covered only for the period of time the attendant has responsibility for hands-on care of the recipient. Stand-by time is not covered.

HOME-BASED PERSONAL CARE SERVICES

Home-based personal care services are covered benefits when provided by an agency licensed to provide personal care outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21. The services are delivered by a personal care aide or a home health aide (performing only personal care level tasks) who has obtained a certificate of completion from the State Office of Education, or a licensed practical nurse, or a licensed registered nurse.

LIMITATIONS

1. Home-based personal care services are covered benefits when prescribed by a physician.

2. Home-based personal care services are not covered benefits: (a) for recipient's residing in an institution, or (b) when delivered current with Medicaid home health aide services.

3. Home-based personal care services are limited to 60 hours per month.

EMPLOYMENT-RELATED PERSONAL CARE SERVICES

Employment-related personal care services are covered benefits provided to support integrated employment opportunities for individuals with a moderate to severe level of disabilities. Services are delivered by an agency licensed to provide personal care services outside of a 24-hour supervised living setting, in accordance with Utah Code Annotated, Title 26, Chapter 21, or a non-agency individual employed by the recipient as a personal care assistant who meets provider qualifications established by the Medicaid Agency. Employment-related personal care services include physical assistance and cognitive cuing to direct self-performance of necessary activities.

LIMITATIONS

A. Employment-related personal care services are covered benefits only for recipients who:
   1. meet the disability definition of the SEC 1614 [42 /y,/s,/c, 1382c](a)(3), and
   2. are gainfully employed in an integrated community setting.

B. Employment-related personal care services are limited to:
   1. assistance with daily living activities;
   2. assistance with instrumental activities of daily living;
   3. transportation to and from the worksite;
   4. case management support to access and coordinate services and supports available at the work site through education, vocational rehabilitation, and other work-related public programs; and
   5. case management support to access and coordinate employment-related personal care services with other Medicaid State Plan services, including home-based personal care services
   6. services provided to eligible individuals outside the home necessary to assist them in obtaining and retaining competitive employment of at least 40 hours per month. Services are designed to assist an individual with a disability to perform daily activities on and off the job that the individual would typically perform if they did not have a disability.

C. Employment-related personal care services are not covered benefits:
   1. when provided by a legally responsible family member or guardian;
   2. when provided to individuals residing in hospitals, nursing facilities, ICFs/MR, when the recipient is employed by the facility; or
   3. when provided to individuals enrolled in a 1915(c) Home and Community-Based Services waiver when personal care services are provided as a component of a covered waiver services currently being utilized by the recipient.

EMPLOYMENT-RELATED PERSONAL CARE SERVICES (Continued)

D. Scope, amount, and duration of employment-related personal care services will be determined on an individual recipient basis through a needs assessment process approved by the Department and completed by staff of the Department or its designee.

E. Scope, amount, and duration of employment-related personal care services will be authorized through completion of a written individualized service plan prepared jointly by the individual recipient and the Department staff or designee conducting the needs assessment.

F. Non-agency personal care assistants employed by the recipient to provide employment-related personal care services are required to utilize a Department approved fiscal intermediary to coordinate Medicaid claims submittal and payment, and to coordinate payment of employer-based taxes.

G. Recipients who cannot direct the activities of a personal care assistance employee may designate a proxy to act in this capacity within parameters established by the Department.